

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025503

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 370 Primary Registration District No. 3058 Registrar's No. 9

STATE FILE NUMBER

FILED JUN 17 1963

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Charles		c. CITY OR TOWN St. Charles	
Length of stay in 1b %5 Days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hosp		d. STREET ADDRESS (If outside, give location) 205 Red Bird Dr	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First Middle Last PAUL RAY SLANKARD		4. DATE OF DEATH Month Day Year June 10 1963	
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Mar 21 1910 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY Electr. Mfg.	
11. BIRTHPLACE (City and state or country) Bernie Missouri		12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME DAVID LEON SLANKARD		13b. MOTHER'S MAIDEN NAME MAMIE BELLARS	
14. NAME OF HUSBAND OR WIFE DOROTHY CARVER SLANKARD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Not		17. INFORMANT Address Dorothy C Slankard St Charles, Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY THROMBOSIS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 3° BURNS BACK, CHEST + LEFT ARM DUE TO (c) 2 WKS		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) SEVERE OSTEO ARTHRITIS		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) CLOTHING CAUGHT FIRE	
20c. TIME OF INJURY Hour Month, Day, Year 9:00 a.m. May 28 1963		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from May 28, 1963, to 6:20 PM JUNE 10 and last saw her alive on JUNE 10		Death occurred at 6:20 PM m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Russell Glider MD (Degree or title)		22b. ADDRESS St Charles, Mo	
22c. DATE SIGNED June 10/63 (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 13 '63	23c. NAME OF CEMETERY OR CREMATORY St Charles Mem Gardens St Charles Mo	
24. FUNERAL DIRECTOR ADDRESS PRINSTER-BAUE, ST CHARLES MO	25. DATE RECD. BY LOCAL REG. 6-14-63	26. REGISTRAR'S SIGNATURE Mabel L. Zimmert (Lep)	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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11 092

12 1-0

13 5-0

601250-80M

JUN 21 1963

JAN 3 1964

CALL-LESTER PRINSTER RA-4-0283

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Frederic W. Bane

Licensed Embalmer, No. 4607

P. O. Address St. Charles, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.